

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0019489</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Manorcare at Westmont</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>06/01/00</u> to <u>05/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>512 East Ogden Ave.</u> <u>Westmont</u> <u>60559</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Du Page</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u> (Title) <u>Vice President - Director of Reimbursement</u>																									
Telephone Number: <u>(630)323-4400</u> Fax # <u>(630)323-4583</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																									
IDPA ID Number: <u>520970446001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>05/01/77</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Gary Geise</u> Telephone Number: <u>(419)252-5731</u>																											

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Westmont# 0019489 Report Period Beginning: 06/01/00 Ending: 05/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>155</u>	Skilled (SNF)	<u>155</u>	<u>56,575</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>155</u>	TOTALS	<u>155</u>	<u>56,575</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>413</u>	<u>1,203</u>	<u>12,214</u>	<u>13,830</u>	8
9	SNF/PED					9
10	ICF	<u>16,860</u>	<u>8,934</u>	<u>994</u>	<u>26,788</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,273</u>	<u>10,137</u>	<u>13,208</u>	<u>40,618</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 71.79%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/01/77

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 47 and days of care provided 8,165Medicare Intermediary CareFirst of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/01 Fiscal Year: 05/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

Manorcare at Westmont

0019489

Report Period Beginning:

06/01/00

Ending:

05/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	261,047	18,676	8,809	288,532	1,916	290,448		290,448			1
2	Food Purchase		149,769		149,769		149,769	(113)	149,656			2
3	Housekeeping	108,427	20,470	759	129,656		129,656		129,656			3
4	Laundry	42,509	19,061		61,570		61,570		61,570			4
5	Heat and Other Utilities			158,186	158,186	8,783	166,969		166,969			5
6	Maintenance	34,822	15,391	39,802	90,015		90,015		90,015			6
7	Other (specify):* Medical Waste			4,530	4,530		4,530		4,530			7
8	TOTAL General Services	446,805	223,367	212,086	882,258	10,699	892,957	(113)	892,844			8
	B. Health Care and Programs											
9	Medical Director			20,250	20,250		20,250		20,250			9
10	Nursing and Medical Records	2,092,005	176,602	7,799	2,276,406	34,713	2,311,119		2,311,119			10
10a	Therapy	473,375	2,350	120,058	595,783		595,783		595,783			10a
11	Activities	68,575	3,563	1,330	73,468		73,468		73,468			11
12	Social Services	43,904	101		44,005		44,005		44,005			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,677,859	182,616	149,437	3,009,912	34,713	3,044,625		3,044,625			16
	C. General Administration											
17	Administrative	70,995		383,847	454,842	(74,571)	380,271		380,271			17
18	Directors Fees											18
19	Professional Services			27,149	27,149	(27,149)						19
20	Dues, Fees, Subscriptions & Promotions			126,588	126,588		126,588	(36,182)	90,406			20
21	Clerical & General Office Expenses	236,701	48,826	66,543	352,070	27,149	379,219	(46,669)	332,550			21
22	Employee Benefits & Payroll Taxes			569,110	569,110	(18,372)	550,738		550,738			22
23	Inservice Training & Education			2,211	2,211		2,211		2,211			23
24	Travel and Seminar			4,134	4,134		4,134		4,134			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			35,690	35,690		35,690		35,690			26
27	Other (specify):* Personal Purchases											27
28	TOTAL General Administration	307,696	48,826	1,215,272	1,571,794	(92,943)	1,478,851	(82,851)	1,396,000			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,432,360	454,809	1,576,795	5,463,964	(47,531)	5,416,433	(82,964)	5,333,469			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Westmont

#0019489

Report Period Beginning:

06/01/00

Ending:

05/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			264,052	264,052	47,531	311,583		311,583			30
31	Amortization of Pre-Op. & Org.			29,004	29,004		29,004		29,004			31
32	Interest											32
33	Real Estate Taxes			81,277	81,277		81,277		81,277			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			47,724	47,724		47,724		47,724			35
36	Other (specify):*											36
37	TOTAL Ownership			422,057	422,057	47,531	469,588		469,588			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		279,074	15,461	294,535		294,535		294,535			39
40	Barber and Beauty Shops		(859)	19,097	18,238		18,238		18,238			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,961	84,961		84,961		84,961			42
43	Other (specify):* IV Drugs		153,539		153,539		153,539		153,539			43
44	TOTAL Special Cost Centers		431,754	119,519	551,273		551,273		551,273			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,432,360	886,563	2,118,371	6,437,294		6,437,294	(82,964)	6,354,330			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning: 06/01/00

Ending: 05/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(113)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,180)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(374)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,986)	21		24
25	Fund Raising, Advertising and Promotional	(36,182)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Inc. & Misc.	(18,129)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,964)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (82,964)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Manorcare at Westmont

ID# 0019489

Report Period Beginning: 06/01/00

Ending: 05/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Westmont# 0019489

Report Period Beginning:

06/01/00

Ending:

05/31/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(113)	0	0	0	0	0	0	0	0	0	0	(113)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(113)	0	0	0	0	0	0	0	0	0	0	(113)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(36,182)	0	0	0	0	0	0	0	0	0	0	(36,182)	20
21	Clerical & General Office Expenses	(46,669)	0	0	0	0	0	0	0	0	0	0	(46,669)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(82,851)	0	0	0	0	0	0	0	0	0	0	(82,851)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,964)	0	0	0	0	0	0	0	0	0	0	(82,964)	29

Summary B

Facility Name & ID Number	Manorcare at Westmont	#	0019489	Report Period Beginning:	06/01/00	Ending:	05/31/01
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Manorcare at Westmont# 0019489

Report Period Beginning:

06/01/00

Ending:

05/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE H.O. COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	Cost Per General Ledger	4	5	Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount		Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 383,847		HCR ManorCare, Inc.	100.00%	\$ 383,847		1
2	V	Page								2
3	V	8								3
4	V									4
5	V									5
6	V	10a	Therapy Management	50,500		Heartland Management Services	100.00%	50,500		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			\$ 434,347				\$ 434,347	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Westmont # 0019489 Report Period Beginning: 06/01/00 Ending: 05/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Manorcare at Westmont# 0019489

Report Period Beginning:

06/01/00Ending: 05/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR ManorCare, Inc.Street Address 333 North Summit St.City / State / Zip Code Toledo, OH 43604Phone Number (419) 252-5500Fax Number (419) 254-5495

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>Dietary - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac.</u>	<u>\$</u>	<u>\$</u>		<u>0</u>	1
2	<u>Dietary - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac.</u>	<u>671,002</u>	<u>407,536</u>	<u>5,900,439</u>	<u>1,916</u>	2
3	<u>Utilities - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac.</u>	<u>262,823</u>		<u>5,900,439</u>	<u>854</u>	3
4	<u>Utilities - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac.</u>	<u>2,777,349</u>		<u>5,900,439</u>	<u>7,929</u>	4
5	<u>Nursing - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac.</u>	<u>6,096,791</u>	<u>4,282,378</u>	<u>5,900,439</u>	<u>19,806</u>	5
6	<u>Nursing - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac.</u>	<u>5,221,432</u>	<u>3,383,186</u>	<u>5,900,439</u>	<u>14,907</u>	6
7	<u>General & Admin. - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac.</u>	<u>23,025,730</u>	<u>19,694,773</u>	<u>5,900,439</u>	<u>74,801</u>	7
8	<u>General & Admin. - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac.</u>	<u>82,128,599</u>	<u>31,955,235</u>	<u>5,900,439</u>	<u>234,475</u>	8
9	<u>Employees Benefits - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac.</u>	<u>2,724,065</u>		<u>5,900,439</u>	<u>8,849</u>	9
10	<u>Employees Benefits - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac.</u>	<u>(9,534,453)</u>		<u>5,900,439</u>	<u>(27,221)</u>	10
11	<u>Depreciation - Direct</u>	<u>Accumulated Cost</u>	<u>1,816,305,362</u>	<u>357 Nurs. Fac.</u>	<u>74,480</u>		<u>5,900,439</u>	<u>242</u>	11
12	<u>Depreciation - Pooled</u>	<u>Accumulated Cost</u>	<u>2,066,722,869</u>	<u>357 Nurs. Fac.</u>	<u>16,563,680</u>		<u>5,900,439</u>	<u>47,289</u>	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 130,011,498	\$ 59,723,108		\$ 383,847	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Westmont COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0019489

CONTACT PERSON REGARDING THIS REPORT Gary Geise

TELEPHONE (419)252-5731 FAX #: (419)252-5548

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-03-207-014</u>	<u>See attached</u>	\$ <u>80,739.38</u>	\$ <u>80,739.38</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>80,739.38</u></u>	\$ <u><u>80,739.38</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

30,739

B. General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

2

C.

Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1977	\$ 195,699	1
2					2
3	TOTALS			\$ 195,699	3

Facility Name & ID Number Manorcare at Westmont# 0019489

Report Period Beginning:

06/01/00

Ending:

05/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	\$ 1,372,073	\$ 42,689		\$ 42,689	\$	\$ 858,243	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CURRENT YEAR DEPRECIATION					110,035		110,035		900,020	9
10				1985	42,165						10
11				1986	9,808						11
12				1987	118,541						12
13				1988	118,593						13
14				1989	58,768						14
15				1990	15,910						15
16				1991	58,674						16
17				1992	84,338						17
18				1993	50,656						18
19				1994	697,677						19
20				1995	184,192						20
21				1996	125,462						21
22				1997	93,215						22
23		ELECTRICAL		1998	836						23
24		HVAC WORK		1998	560						24
25		PLUMBING		1998	2,934						25
26		CARPET		1998	622						26
27		PAINTING/WALLCOVERING		1998	38,975						27
28		PLUMBING		1998	11,610						28
29		ELECTRICAL		1998	41,203						29
30		DEVELOPERS		1998	7,300						30
31		FLOORING/CEILING		1998	21,486						31
32		LIGHT FIXTURE		1998	673						32
33		HVAC		1998	2,611						33
34		DOOR/WINDOW		1998	10,656						34
35		SIGN		1998	11,914						35
36		CARPENTRY		1998	55,367						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	MILLWORK	1998	\$ 6,043	\$		\$	\$	\$		37
38	FINISH STUDS	1998	28,900							38
39	GENERAL REQUIREMENT	1998	11,534							39
40	FUNDATION WORK	1999	229							40
41	BUILDING IMPROVEMENTS	1999	2,952							41
42	ELECTRICAL	2000	4,668							42
43	FIRE RATE CEILING	2000	890							43
44	CEDAR GATES	2000	875							44
45	FENCE	2000	3,391							45
46	PARKING LOT PAVING	2000	5,500							46
47	FIRE RATE CEILING & STEEL DOORS	2000	17,960							47
48	PAINTING-DOORS	2000	2,000							48
49	EYEWASH STATION	2000	2,545							49
50	FIRE RATE CEILINGS	2000	19,901							50
51	KEYPADS-FRONT & BACK ENTRANCES	2000	1,938							51
52	RESIDENT DOORS	2000	26,220							52
53	NURSE CALL SYSTEM	2001	44,342							53
54	MISC. RENOVATIONS	2001	28,041							54
55	MISC. RENO - CURTAINS & DRAPES	2001	12,890							55
56	MISC. RENO - CARPENTRY	2001	58,208							56
57	MISC. RENO - FLOOR & WALL COVERING	2001	30,915							57
58	MISC. RENO - PLUMBING	2001	3,572							58
59	MISC. RENO - ELECTRICAL	2001	13,783							59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,564,116	\$ 152,724		\$ 152,724	\$	\$ 1,758,263		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,002,382	\$ 111,328	\$ 111,328	\$		\$ 761,503	71
72	Current Year Purchases	77,575						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			47,531	47,531			74
75	TOTALS	\$ 1,079,957	\$ 111,328	\$ 158,859	\$ 47,531		\$ 761,503	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,839,772	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 264,052	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 311,583	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47,531	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,519,766	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	STEP-UP BUILDING	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 47,724 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elct. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	3861	hrs	\$ 96,216		\$	1,286	3,861	\$ 97,502	1
2	Licensed Speech and Language Development Therapist	10a	675	hrs	23,637	59	1,465	72	734	25,174	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	4841	hrs	135,344	1	31	992	4,842	136,367	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39,2		# of prescrpts				279,074		279,074	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-ray, EKG, & Lab	39,3					15,461			15,461	13
14	TOTAL				\$ 255,197	60	\$ 16,957	\$ 281,424	9,437	\$ 553,578	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning: 06/01/00

Ending:

05/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 05/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 225,366	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (254,795))	1,306,157		3
4	Supply Inventory (priced at)	13,494		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,961		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,549,978	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	195,699		13
14	Buildings, at Historical Cost	3,564,116		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,079,957		16
17	Accumulated Depreciation (book methods)	(2,519,766)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,320,006	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,869,984	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 10,368	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	280,475		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,683		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Trade Payable & Liabilities	87,354		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 452,880	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 452,880	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,417,104	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,869,984	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,251,570	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,251,570	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	952,931	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 952,931	17
	B. Transfers (Itemize):		
18	Change in Interdivision	(787,397)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (787,397)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,417,104	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Westmont

0019489

Report Period Beginning: 06/01/00

Ending: 05/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,808,009	1
2	Discounts and Allowances for all Levels	(2,603,619)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,204,390	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,766,644	6
7	Oxygen	4,299	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,770,943	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,544	12
13	Barber and Beauty Care	21,559	13
14	Non-Patient Meals	113	14
15	Telephone, Television and Radio	11,180	15
16	Rental of Facility Space		16
17	Sale of Drugs	292,609	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	48,966	19
20	Radiology and X-Ray		20
21	Other Medical Services	40	21
22	Laundry	14,992	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 391,003	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	16,585	28
28a	Late charges	7,304	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,889	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,390,225	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	882,258	31
32	Health Care	3,009,912	32
33	General Administration	1,571,794	33
B. Capital Expense			
34	Ownership	422,057	34
C. Ancillary Expense			
35	Special Cost Centers	466,312	35
36	Provider Participation Fee	84,961	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,437,294	40
41	Income before Income Taxes (line 30 minus line 40)**	952,931	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 952,931	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Manorcare at Westmont# 0019489Report Period Beginning: 06/01/00Ending: 05/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,757	3,040	\$ 84,542	\$ 27.81	1
2	Assistant Director of Nursing	1,371	1,512	37,795	25.00	2
3	Registered Nurses	19,446	21,440	491,992	22.95	3
4	Licensed Practical Nurses	38,818	42,799	622,619	14.55	4
5	Nurse Aides & Orderlies	98,648	108,766	832,272	7.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	9,452	10,402	280,841	27.00	7
8	Rehab/Therapy Aides	10,941	12,040	192,534	15.99	8
9	Activity Director	5,508	6,093	68,575	11.25	9
10	Activity Assistants					10
11	Social Service Workers	3,193	3,527	43,904	12.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,404	29,221	261,047	8.93	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,125	34,822	16.39	17
18	Housekeepers	11,552	12,792	108,427	8.48	18
19	Laundry	5,304	5,848	42,509	7.27	19
20	Administrator	1,995	2,080	70,995	34.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,443	18,460	236,700	12.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,185	22,786	10.43	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,728	282,330	\$ 3,432,360 *	\$ 12.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	20,250	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	28,363	10a, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 48,613		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount			
Jeanne Hansen	Administrator June	0%	\$ 5,916	Workers' Compensation Insurance	\$ 44,814	IDPH License Fee	\$ 1,150			
Donna Bellocchio	Administrator Jul-May	0%	65,079	Unemployment Compensation Insurance	23,096	Advertising: Employee Recruitment	82,117			
				FICA Taxes	247,763	Health Care Worker Background Check (Indicate # of checks performed <u>83</u>)	1,251			
				Employee Health Insurance	193,384	Dues & Subscriptions				
				Employee Meals		Association Dues	5,888			
				Illinois Municipal Retirement Fund (IMRF)*		Advertising	35,422			
				Employee Appreciation	4,181	Public Relations	760			
				401K	22,624					
				Other Employee Benefits	30,352					
				SMSP Match						
				Disability Payments	2,512	Less: Public Relations Expense	(760)			
				Tuition Program	384	Non-allowable advertising	(35,422)			
				Home Office Allocation	(18,372)	Yellow page advertising	(

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

<p>Facility Name & ID Number Manorcare at Westmont</p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>IHCA \$5888</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? _____</p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>40,884</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>84,961</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># 0019489 Report Period Beginning: 06/01/00 Ending: 05/31/01</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>113</u></p> <p>(16) Travel and Transportation</p> <p>a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.</p> <p>b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____</p> <p>c. What percent of all travel expense relates to transportation of nurses and patients? <u>N/A</u></p> <p>d. Have vehicle usage logs been maintained? <u>N/A</u></p> <p>e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u></p> <p>f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____</p> <p>g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>No</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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